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FISCAL IMPACT STATEMENT

LS 7776
BILL NUMBER: SB 503

NOTE PREPARED: Apr 9, 2007
BILL AMENDED: Apr 9, 2007

SUBJECT: Healthier Indiana Insurance Program.

FIRST AUTHOR: Sen. Miller
FIRST SPONSOR: Rep. C. Brown

BILL STATUS: 2nd Reading - 2nd House

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State and Local

Summary of Legislation: (Amended) *Healthier Indiana Insurance Program:* This bill establishes the Healthier Indiana Insurance Program and the Healthier Indiana Insurance Trust Fund. The bill specifies requirements for the program, including premium assistance, eligibility and enrollment, contracting, financial obligations, and funding requirements. The bill provides that the Office of Medicaid Policy and Planning (OMPP) may not enroll applicants, approve any contracts to provide services or administer the Program, incur costs other than those necessary to study and plan for the Program, or create financial obligations for the state unless: (1) there is a specific appropriation from the General Assembly to implement the Program; and (2) after review by the Budget Committee, the Budget Agency approves an actuarial analysis that determines sufficient funding is reasonably estimated to be available to operate the program for at least the following eight years.

The bill requires the OMPP to apply to the United States Department of Health and Human Services for a demonstration waiver to develop and implement the Healthier Indiana Insurance Program to cover certain individuals.

Health for High-Risk Hoosiers Program: The bill requires the Indiana Comprehensive Health Insurance Association (ICHIA) to provide, and referred program participants to participate in, medical management services.

Availability of Healthier Indiana Insurance Plan to Individuals and Employers: The bill requires insurers contracting to provide insurance policies for the Healthier Indiana Insurance Program with the Office to make the same health insurance available to individuals and certain employers meeting certain specifications.

Hospital Payment Changes: The bill makes funding changes to the Hospital Care for the Indigent Program (HCI), the Municipal Disproportionate Share Program, and the Medicaid Indigent Care Trust Fund.

Hospital Care for the Indigent Property Tax Levy Revisions: The bill amends the formula in determining a county's Hospital Care for the Indigent property tax levy and the applicable years.

Reporting: The bill requires the Office of Medicaid Policy and Planning to report to the Health Finance Commission regarding the status of the development and implementation of the Healthier Indiana Insurance Program during the 2007 interim session.

Small Employer Health Insurance Purchasing Pool: The bill would require the Department of Insurance and the Office of the Secretary to implement a program to allow certain small employers to join together to purchase health insurance.

Tax Credit: The bill provides for a tax credit related to employee wellness programs.

Medicaid and CHIP Provisions: The bill increases the income limit for Medicaid eligibility for pregnant women and infants up to age 1 year from 150% to 200% of the federal income poverty level. It provides for 12 continuous months of eligibility for an eligible child under Medicaid or the Children's Health Insurance Program (CHIP). It also requires that OMPP require a foster care Medicaid recipient to participate in the risk-based managed care program. The bill increases the CHIP eligibility family income limit from 200% to 300% of the federal income poverty level. The bill also requires application for necessary federal Medicaid approval, including presumptive eligibility for certain pregnant women.

The bill allows OMPP to develop: (1) a premium assistance program; and (2) subject to approval and funding, a health care account program for individuals who have an annual income of more than 200% but not more than 300% of the federal poverty level.

The bill requires private health insurers and health maintenance organizations to cover children up to 24 years old upon request.

The bill allows local units and small employers to elect to provide employee health coverage through the state employee health plans.

The bill establishes the Healthier Indiana Insurance Program Task Force. It makes conforming and technical changes.

The bill establishes the Rural Health Care Pilot Program and Fund.

The bill prohibits smoking in certain places and establishes a new Class A infraction for violations of the provision.

The bill makes an appropriation.

Effective Date: Upon passage; July 1, 2007.

Summary of Net State Impact: *Healthier Indiana Insurance Program:* The bill establishes the Healthier Indiana Insurance Program as a demonstration waiver project under the state Medicaid program. The program

is to provide health insurance to individuals having an annual household income of not more than 200% of the federal poverty level (FPL). Custodial parents may be added to the eligible population of Medicaid and CHIP and would be considered an eligibility expansion group. Childless adults are typically not eligible for Medicaid unless certain disability or age and income standards are met. The Office would need to demonstrate fiscal neutrality within the program in order to add this group in the demonstration waiver. Medicaid waivers, by definition must demonstrate fiscal neutrality and are approved and monitored by the Centers for Medicare and Medicaid Services (CMS) for fiscal neutrality through the term of the demonstration. The bill does not entirely delineate the funding mechanism for this program. Changes made to the financial eligibility levels, the defined contribution limits, the required benefits, and re-enrollment periods will increase the estimated cost of the subsidies and premiums in the program which will cause a decrease in the number of potential participants. The extent that the increased cost will influence the number of participants the state can subsidize will be dependent upon the amount of funding the General Assembly makes available and the level of the subsidy to fund the required benefits.

The bill will also cap Hospital Care for the Indigent (HCI) funds used to leverage federal funds for HCI add-on payments to hospitals at $11.65 M. This provision will guarantee total hospital payments of $30.66 M (the amounts paid in FY 2006). The bill further provides that for fiscal years after FY 2006, all intergovernmental transfers deposited into the Medicaid Indigent Care Trust Fund shall be used for Medicaid supplemental payments, disproportionate share DSH payments, and the transfer of $30 M to OMPP for Medicaid expenditures.

The bill also changes the method by which the HCI levy is determined for 2008 and thereafter; effectively capping the levy at the 2007 level.

The Employer Wellness Program tax credit could potentially reduce revenue by $600,000 to $2.5 M annually beginning in FY 2009. The revenue loss could begin in FY 2008 if taxpayers adjust their quarterly estimated payments.

Medicaid and CHIP 12-month continuous eligibility is estimated to cost in excess of $23 M in state General Funds annually.

The bill also requires a Medicaid State Plan amendment to expand Medicaid eligibility for pregnant women and infants from 150% of the FPL to 200%. This provision would create an entitlement for services to a total population estimated by OMPP to be approximately 14,733 pregnant women and an equal number of infants. Total cost of this provision is estimated to be $160.1 M, or approximately $60.9 M in state General Funds.

The bill requires the Medicaid State Plan be amended to include presumptive eligibility for pregnant women. The cost of this provision is not known at this time.

The bill requires the Office to enroll foster children who are Medicaid recipients, less than age 18, and not disabled to be enrolled in a risk-based managed care program. Depending on individual circumstances, this provision could result in an unknown level of savings to the Medicaid Program.

Employer-sponsored Health coverage for children to age 24 is estimated to have a state fiscal impact of $4.6 M.

Expansion of the risk pool for state employee health benefit plans would have an indeterminate fiscal impact.

The range of total expense for the expansion of CHIP eligibility to 300% of the FPL is estimated to be between $31.7 M to $43.2 M in FY 2007. The state General Fund share is estimated to be $12.0 M to $16.4 M at the lower Medicaid FMAP (federal medical assistance percentage) rate since enhanced CHIP funding is capped.

The Healthier Indiana Insurance Program Task Force costs should be absorbed within the resources available to the Office of the Secretary of the Family and Social Services Administration.

The bill establishes the Rural Health Care Pilot Program Support Fund for the purpose of making grants to provide matching funds for the Federal Communication Commission (FCC) grant program aimed at helping public and nonprofit health care providers build state and regional broadband networks.

The bill appropriates from the Healthier Indiana Insurance Trust Fund for the biennium; $15 M for increased Medicaid payments for services provided by primary care physicians; and $250,000 for the Rural Health Care Pilot Program.

Explanation of State Expenditures:

Details on the Healthier Indiana Insurance Program -

Medicaid Waiver and Conditions for Program Implementation: The bill establishes the Healthier Indiana Insurance Program and requires OMPP to apply for a Medicaid demonstration waiver to develop and implement the Program. The bill specifies that the Program is not an entitlement and participation is dependent upon the level of funding appropriated for the Program. The bill specifies that OMPP may not enroll applicants, approve contracts, or otherwise create a financial obligation for the state other than costs necessary to study and plan for the implementation of the Program without a specific appropriation to implement the Program made by the General Assembly. The bill further specifies the Program may not be implemented until an actuarial analysis, reviewed by the Budget Committee and approved by the State Budget Agency demonstrates that sufficient funding is available to operate the program for at least 8 years. OMPP is authorized to adopt emergency rules to implement the Program on an emergency basis.

Eligibility: Individuals eligible for the Program must be over age 18 and under age 65, U.S. citizens, and residents of Indiana for at least 12 months. Eligible individuals may not be eligible for Medicare or Medicaid as a disabled person. Pregnant women are not eligible for services related to the pregnancy. Individuals must not be eligible for health insurance coverage through an employer, and they must have been uninsured for at least 6 months or uninsured due to a job change. Individuals and married couples must apply for the Program, be approved by FSSA, and make defined, timely contributions to an individual Health Care Account, established to help the individual pay the deductible for health care services offered under the Program. The Healthier Indiana Insurance Program will add two groups of eligible individuals; custodial parents and childless adults. Custodial parents may be added to the eligible population of Medicaid and CHIP and would be considered an eligibility expansion group. Childless adults are typically not eligible for Medicaid unless certain disability or age and income standards are met. The Office would need to demonstrate fiscal neutrality within the program in order to add this group in the demonstration waiver.

Financial Eligibility: The parent of a child having an annual household income of not more than 200% of the FPL, is eligible for the Program. The legal spouse of a parent is also eligible for the program. Single individuals having an annual household income of not more than 200% of the FPL are also eligible. The bill does not require the income to be earned income nor does it define an age limit for children living in a home.

Federal income poverty level guidelines for 2007 are included in the table below.

Persons in the Family or Household	100%	200%	300%
1	$10,210	$20,420	$30,630
2	$13,690	$27,380	$41,070
3	$17,170	$34,340	$51,510
4	$20,650	$41,300	$61,950

Terms of Participation: Individuals approved for participation, are eligible for 12 months, contingent upon timely payment of the required contribution At the end of the 12-month period, the individual must apply for a renewal in order to continue Program participation. Certain individuals, defined as high-risk, are also required to participate in the High Risk Hoosiers Program which requires participation by an individual in medical management services. An individual that fails to make a Health Care Account contribution within 60 days of the required payment, may be terminated from the Program. Individuals who are terminated for nonpayment of the required contributions or who do not renew their participation after the end of the 12-month enrollment period may not reapply to participate in the program for at least 3 months.

Health Care Accounts: Participants in the Program must have Health Care Accounts. Up to 50% of the required contributions to the accounts may be made by employers withholding after-tax payroll dollars on the employee's behalf, or directly by an individual in a manner to be prescribed by OMPP. The Health Care Account is to be available to meet the individual's deductible expenses required before the insurance policy purchased on their behalf by the Program assumes the cost of subsequent medical expenses. The state is required to subsidize the Account based on the income level of the participant.

Health Care Account Contributions: Individuals are required to contribute at least $1,100 per year, but not more than 2% of the individual's annual household income if the household income level is below 150% of the FPL, or not more than 3% of the individual's annual household income if the household income level is more than 150% but not more than 200% of the FPL. The bill provides that the required contribution for an individual's household includes any contributions to the Children's Health Insurance Program (CHIP) or to the Medicaid Program. This provision would allow parents to reduce their required 2% or 3% contribution by the amount of CHIP C premiums and CHIP, Medicaid, or Medicare copayments made for the household. CHIP C premiums range from $22 to $50 per month depending on the household income level and the number of children in the household. CHIP C children may also have copayments for prescription drugs and emergency transportation services which could be deducted. (CHIP C financial eligibility is determined by households with incomes greater than 150% of FPL but less than 200% FPL.) The bill prohibits Medicaid recipients from participating in the Program, but a qualifying individual may have a Medicaid recipient as a member of their household. Federal regulations prohibit states from assessing copayments for Medicaid children (less than 150% FPL); certain Medicaid recipients in the aged, blind, or disabled eligibility categories could have prescription drug copayments assessed. While the bill would prohibit Medicare participants from participating in the Program, household members may be Medicare-eligible (e.g., an elderly parent, or a disabled adult or child), and Medicare-associated premiums, copayments and deductibles could reduce the individual's required contribution as determined by OMPP. The highest contribution that could be required from any individual would be the minimum dollar amount required for the account of $1,100 annually, or $91.67 per month. The bill addresses each covered individual's requirements and appears to

indicate that each covered individual must have a Health Care Account. The bill is not specific with regard to the treatment of contributions and Account requirements for legal spouses.

The bill would require the state to contribute any difference between the calculated required individual contribution and the minimum amount required for contribution to the account of $1,100. The total cost of the subsidy required would be dependent upon the number of individuals enrolling and the level of the required contributions for each enrolled individual.

Withdrawals from the Health Care Account: The Health Care Account is to be used through the year to pay deductible expenses incurred for health care services, excluding the defined preventive care services up to the minimum dollar amount required of $1,100. At the end of each 12-month enrollment period, individuals who have received the preventive care services defined by OMPP and who renew their participation in the Program, will have any unused individual contributions remaining in the account applied to reduce the required amount they must contribute to the Account in the next 12-month enrollment period. Individuals no longer eligible for the program due to increased income, those terminated for failure to make timely Account contributions, or those choosing not to re-enroll in the Program, may withdraw funds to the extent they were contributed to the account by the individual. Money remaining in an account at the end of the 12 month period that is not withdrawn as allowed or applied to the next year's contributions is forfeited and reverts to the state to be deposited in the Healthier Indiana Insurance Fund.

Covered Services: The program is required to provide preventive care services, to be defined by OMPP, for a covered individual up to $500 per year at no cost to the covered individual. The bill also specifies that individuals may be held responsible for non-emergency use of hospital emergency department services; individuals may be required to pay for these services outside of the Health Care Account. Services related to pregnancy are not included in the program. Dental and vision services will not be covered by the Program but may be covered if the individual pays an additional defined premium. The bill specifies that the Program must include mental health services, including substance abuse treatment, inpatient hospital services, prescription drug coverage, emergency services, physician office services, diagnostic services, outpatient services including therapies, comprehensive disease management, home health services, urgent care center services, preventive care services, family planning services including contraceptives, and hospice services. The Office is to determine the manner and extent to which these services are included.

The bill requires the state to annually assume up to $500 cost for the defined preventive health care services for individuals. Up to $500 is to be paid at no cost to participating individuals. The bill does not specify if this benefit is to be administered by or covered under the high-deductible health care insurance policy issued by the insurers.

(Revised) *Insurers:* Health benefits insurers or health maintenance organizations (insurers) that contract with OMPP to provide health care insurance under this program may not deny coverage to an eligible individual who has been approved by OMPP unless the maximum coverage levels are met ($300,000 for the annual individual maximum and $1M for the individual lifetime maximum). Insurers are responsible for claims processing and are required to reimburse providers at rates equal to Medicare reimbursement rates for the services provided or at 130% of the applicable Medicaid reimbursement rate if there is no corresponding Medicare rate. The bill further provides that Insurers that contract to provide health care insurance under this program must also make the same health insurance available to individuals that may be waiting for an available Program slot or with income that exceeds the financial eligibility limits for the Program. The Insurers must also make the same health insurance available to the employees of an employer that pays at least 50% of the premium and has not offered health insurance as an employment benefit in the previous 6

months. The bill further provides that the program policies must comply with any health coverage requirement necessary for an accident and sickness policy issued in the state. The bill is not specific with regard to the administrative responsibility for the establishment and operations of the Health Care Accounts.

Healthier Indiana Insurance Trust Fund: The bill establishes the dedicated, non-reverting Healthier Indiana Insurance Trust Fund to: (1) administer the Program; (2) provide Program co-payments (Account subsidies), preventive care services, and insurance premiums; (3) fund tobacco use prevention and cessation programs; and (4) fund programs to promote the general health and well-being of Hoosiers. The Fund is to be administered by FSSA. Money in the Trust Fund may not be transferred, assigned, or moved from the Fund by FSSA, the State Budget Agency, or the State Board of Finance. The expenses of administering the Fund are to be paid from money in the Fund. The Treasurer is authorized to invest money in the Fund in the same manner as other public funds may be invested.

The Fund is to consist of Cigarette Tax and Tobacco Products Tax revenues designated by the General Assembly to be allocated to the fund; other dedicated funds designated to be appropriated to the fund; available federal funds; and gifts or donations.

Health for High-Risk Hoosiers Program: The bill establishes the High-Risk Hoosiers Under the Healthier Indiana Insurance Program (High-Risk Program) to be administered by the Indiana Comprehensive Health Insurance Program (ICHIA). ICHIA will administer the medical management services that are required to be covered for individuals who are determined by FSSA, using criteria to be developed, to be too high-risk to participate in the insurance pool for the Healthier IN Program. The bill provides that individuals covered by the Healthier Indiana Insurance Program are eligible for the High-Risk Program but, they must be referred by FSSA and are required to participate in medical management services.

Hospital Care for the Indigent (HCI) Program Changes: The bill would freeze hospital payments under the HCI program at FY 2006 levels. This provision would allow hospitals to once again, discontinue submitting claims for the HCI program to OMPP for processing. Hospitals were required to resume submitting claims for purposes of calculating the county property tax levy requirements in FY 2004. OMPP would also realize a decrease in claims processing volume as a result. By way of reference to the volume of work involved, OMPP had approximately 30,922 applications for reimbursement under the HCI program in FY 2006; 11,320 hospital claims were processed for a total amount of $31.3 M priced at Medicaid reimbursement rates. Hospitals are not currently reimbursed for claims, rather they receive HCI add-on payments leveraged for federal reimbursement available within the Medicaid program.

This bill designates $11.65 M of HCI funds to be leveraged with federal funds by methods to be determined by OMPP that will provide hospitals with approximately $30.66 M in total payments. The bill specifies that the payments distributed must equal the amount of the 2006 claim payments. The $11.65 M is reported to be the amount necessary to distribute the same level of funding to the hospitals as was provided in FY 2006.

The bill provides that HCI physician and emergency transportation claims would continue to be submitted, processed, and reimbursed for services up to a maximum amount of $3 M per year. This group submitted 30,968 claims that were priced at Medicaid reimbursement rates for $4.4 M in FY 2006. Since the pool of dollars available for reimbursement for this group is capped at $3 M, in FY 2006 each provider's claims were proportionally reduced and paid at approximately 67.86% of the Medicaid rate for the services provided. HCI program administration costs are also payable from the Fund.

The bill specifies that the remainder of the HCI funds after the $3 M for physicians and transportation

services and the program administration costs are to be transferred to the Medicaid Indigent Care Trust Fund to be used to make supplemental hospital payments under the DSH and municipal DSH programs. In addition the Office is authorized to transfer $30 M annually to the Medicaid program. (Currently the Office transfers $21 M.) In 2007, the gross HCI levy will raise $61.2 M.

The bill specifies that for each fiscal year after FY 2006, the total municipal DSH hospitals shall be capped at $35 M. Municipal DSH hospitals are defined as county and municipal hospitals that have a Medicaid utilization rate greater than 1%. This group previously received about $25 M in total under this program. The bill also provides payment caps on Medicaid supplemental payments made to privately owned DSH hospitals.

The bill further provides that for fiscal years after FY 2006, all intergovernmental transfers deposited into the Medicaid Indigent Care Trust Fund shall be used for Medicaid supplemental payments, disproportionate share DSH payments, and the transfer of $30 M to OMPP for Medicaid expenditures.

OMPP is required to apply to the U.S. Department of Health and Human Services for approval of an amendment to the state's upper payment limit program and to make changes to the state's DSH program.

Medicaid and CHIP Provisions:

Details on the Expansion of Medicaid Pregnancy Related Services - The bill requires OMPP to apply for a Medicaid State Plan amendment to expand Medicaid coverage for pregnant women with incomes from 150% of FPL to 200%. A State Plan amendment would create an entitlement status for the new population group.

A Medicaid State Plan amendment could only be applied to the population of pregnant women up to 185% of FPL. However, the state has the flexibility to determine amounts of income that may be disregarded in determining financial eligibility and therefore could effectively implement a medicaid eligibility expansion to 200% of poverty for all pregnant women. The Plan amendment would also be required to cover the additional group of infants born with Medicaid coverage from birth until one year of age. This is a federal requirement. Under CHIP, fewer than 200 of the expansion group of infants already receive services subsidized by the state.

Medicaid Fiscal Impact - Pregnant Women: This provision would create an entitlement for services to a total population estimated by OMPP to be approximately 14,733 pregnant women. The average cost of pregnancy care in the Medicaid program is reported to be $8,421. Total cost of this provision is estimated by OMPP to be $124.1 M, or approximately $47.2 M in state General Funds. (This is the total cost to add the population of pregnant women to Medicaid.)

Medicaid Fiscal Impact - Infants: All children born to mothers with Medicaid benefits are eligible to remain on Medicaid until their first birthday. If it is assumed that 14,733 infants become eligible for Medicaid as a result of the expansion for pregnant women, an additional annual cost of $36.0 M or approximately $13.7 M in state General Funds would result.

CHIP Impact - Infants: Under the CHIP C program, all children in families with income between 150% and 200% of FPL can be covered at low cost to families. The premium amounts are between $22 and $50 per month, based on the family income and the number of family members covered. There are also small co-payments for some services. The expansion of eligibility for pregnant women under the Medicaid program up to 200% of FPL would also include the shift of all current CHIP infants, and any subsequently born, to the Medicaid program. CHIP premium revenue would be reduced by the amount being contributed to cover

children under the age of one year who are in families with income below 200% but above 150% of FPL. FSSA procurement documents estimated the size of this enrolled population to be 189 infants in CHIP C. If all infants projected to be enrolled in CHIP are assumed to be single children, the maximum annual loss of premium revenue would be approximately $50,000.

Medicaid and CHIP Continuous Eligibility: The bill would provide that children under the age of 19 years would be continuously eligible for 12 months following a determination of eligibility for Medicaid or CHIP. In the December of 2002, Medicaid Cost Containment Forecast savings estimated for the Medicaid Program due to eliminating continuous eligibility were $23.5 M for FY 2005. The cost of re-instituting this provision is estimated to be somewhat higher due to increased enrollment. It is not clear from the forecast document if CHIP savings are included in the savings estimate. This provision would also apply to the expansion group added in this bill; children in families with income greater than 200% but not more than 300% of the federal income poverty level (FPL).

Medicaid Presumptive Eligibility for Pregnant Women: The bill requires that OMPP apply for a state plan amendment to include presumptive eligibility for pregnant women. This provision would allow physicians to receive payment for services to pregnant women who are presumed to be eligible for Medicaid rather than waiting for eligibility to be determined. This provision would apply to the current population of eligible women plus the proposed expansion group. The cost of this provision is not known at this time.

CHIP Income Eligibility Increased to 300% of FPL: The bill would increase the income eligibility for CHIP from 200% of the federal income poverty level (FPL) to 300% of FPL. Federal income poverty level guidelines for 2007 are shown in the table above.

U.S. Census data estimate that 56.7% of all children under the age of 18 live in households with income below 300% of the FPL. If this percentage is assumed to remain constant when 18-year-olds are included, the population of children under the age of 19 living in households with more than 200% of the FPL but less than 300% of FPL is estimated to be 304,700 children. If this population is assumed to be similar in health care needs to the population of children in Medicaid or to the CHIP C population, a range of total expense may be estimated to range from $31.7 M to $43.2 M in FY 2007. The state General Fund share is estimated to be $12.0 M to $16.4 M at the lower Medicaid FMAP rate. Federal CHIP funds are annually capped and Indiana expends all of the federal CHIP allotment on the current population. The CHIP statute currently authorizes coverage under the program up to 200% of the FPL. However, the state has the flexibility to determine amounts of income that may be disregarded in determining financial eligibility and therefore could effectively implement an eligibility expansion to 300% of poverty for children - other states have expanded to this level. Additionally, the federal CHIP statute and funding expires this year, and the terms of the reauthorization are unknown at this time.

Medicaid Reimbursement: The Medicaid Program is jointly funded by the state and federal governments. The state share of program expenditures is approximately 38%. Medicaid medical services are matched by the federal match rate (FMAP) in Indiana at approximately 62%. The CHIP program receives enhanced federal reimbursement of approximately 74%. The state share of the CHIP Program is approximately 26% for medical services. Administrative expenditures with certain exceptions are matched at the federal rate of 50%.

Expansion of Risk Pool in State Employee Health Benefit Plans

Employee Health Coverage--Existing State Employee Health Plans: The state currently contracts with

M-Plan and Wellborn (in southern Indiana) for the provision of prepaid health care delivery plans (HMOs). The state also contracts with Anthem to administer the state's self-insurance health plans.

Providing coverage to local governmental units, public libraries, school corporations, and/or certain small employers could affect premium costs, but the specific impact is indeterminable. Whether the impact will be positive or negative will depend on whether the demographics and claims experience of the new populations are found to be at more or less risk. Factors that would have an impact on the costs are outlined below.

Administrative Costs: With respect to the state's self-insurance plans, administrative costs typically make up 15%-20% of the overall benefit costs. Administrative costs are scaled based on the size of the group. There are economies of scale that apply when a large group has the same administration. The larger the group, the lower the charge per member per month (pmpm). Having a large group with the same administration creates cost effectiveness to the administrator. To the extent that the administration can be standardized and efficient in the system, overall health insurance costs can be reduced.

Eligibility Definition: Who is covered by the plans also affects the overall costs. Some units currently cover retirees. This coverage impacts the overall costs since retirees are higher consumers of health care resources. The addition of this population could result in increases for health insurance costs.

Networks: The type of provider network used can also impact costs. For example, using a preferred provider organization (PPO) can impact costs. (PPOs are a group of doctors who sign a contract agreeing to a certain level of payment for certain services.) The impact would depend on networks currently in use by eligible businesses and local units, and how these networks compare to state plans.

Benefits: The level that employees share in the cost of claims through deductibles, co-payments, and coinsurance affects the overall cost per member paid by the plans. Additionally, how benefits provided by eligible businesses and local units compare with existing state plans is unknown at this time.

Separate Versus Combined Risk Pool: With respect to the state self-insurance plan administered by Anthem, the major health care cost difference between a separate versus combined risk pool would be administrative. All other savings (mandatory participation, common benefits and eligibility, administrative practices, etc.) could be duplicated whether the risk pools were separate or combined. If businesses and local units participated with the state employee group in a single risk pool with like administration, there could be some cost savings through lower administrative costs. Any type of voluntary offering creates adverse selection within the pool. The bill allows employees to choose specific benefits.

With respect to HMOs, based on the assumption that providing coverage to eligible businesses and local units would significantly increase the number of members enrolled in the plan and assuming that benefits, eligibility guidelines, enrollment processes, premium payments, and other operational functions are the same, administrative costs would be the same. If eligible businesses and local units are treated as a separate risk pool, it would have no effect on state employee coverage costs. If the eligible businesses, local units, and the state employee group are treated as one risk pool, it is unclear whether the impact would be positive or negative. The impact would depend on the age, sex, health status, etc. of the eligible businesses' and local units' employees and dependents who enroll for coverage relative to state employees and their dependents currently selecting health care coverage. If the proportion of new high-cost, eligible businesses and local units electing to participate in a particular plan exceeds the proportion of new low-cost, eligible businesses and local units electing to participate, then there would be a greater probability that the state employee health

coverage costs would increase.

Employer-Sponsored Health Coverage for Children to Age 24

Health Coverage for Children: As of January 2007, the state enrolled approximately 31,155 state employees in 3 health benefit plans: M-Plan, Anthem, and Wellborn. Total annual premium increases for the 3 plans are estimated to be $4.6 M. The actual impact will likely be less. This increase may not necessarily imply additional budgetary outlays since the state's response to increased health benefit costs may include (1) greater employee cost-sharing in health benefits; (2) reduction or elimination of other health benefits; and (3) passing costs onto workers in the form of lower wage increases than would otherwise occur. It is unknown at this time if the state would absorb added costs or pass the costs on to employees.

Background Information - The following estimates are based on adding coverage up to age 24 for Anthem and Welborn. Estimates for M-Plan are based on coverage until age 26. Estimates for M-Plan for coverage until 24 will be provided when they become available.

Anthem Estimate: Anthem reports that to add coverage up to age 24 would result in a $7.89 increase in per member per month (pmpm). Currently, 20,092 employees are enrolled in an Anthem program. Applying the 2.28 members per employee would result in an Anthem total membership of 45,810. Applying the $7.89 increase per member would result in an increase of $361,440 per month with an annual increase of $4,337,290.

M-Plan Estimate: M-Plan reports that to add coverage up to age 26 would result in a $0.45 increase per employee per month. Currently, 9,797 employees are enrolled in M-Plan. Applying the $0.45 increase per employee would result in an increase of at most $4,408 per month with an annual increase of at most $52,903.

Welborn Estimate: Welborn reports that to add coverage up to age 24 would result in a $6.94 increase pmpm. Currently, 1,266 employees are enrolled in Welborn. Applying the 2.28 members per employee would result in a total membership of 2,886. Applying the $6.94 increase per member would result in an increase of $20,028 per month with an annual increase of $240,346.

Total annual increases for the 3 plans would equal $4,630,539.

Public Employer Wellness Programs and Wellness Program Tax Credits

The bill requires a public employer to provide a wellness program that rewards: (1) overweight employees for losing weight and all employees for maintaining a healthy weight; or (2) employees for not using tobacco. The current state health insurance plan provides a $500 decrease in the employee's health insurance deductible if they commit not to use any form of tobacco in 2007. The state also provided a $10 single and $15 family biweekly reduction in health insurance premium if the employee participated in the One Care Street program. The employee has to complete a survey and set a health action goal. The current state programs satisfy the bill's requirement resulting in no additional state fiscal impact.

Employer Wellness Program Tax Credit: The Department of State Revenue (DOR) will incur some administrative expenses relating to the revision of tax forms, instructions, and computer programs to incorporate the new wellness program tax credit. The Department's current level of resources should be sufficient to implement these changes.

(Revised) *Healthier Indiana Insurance Program Task Force*: The bill would establish the Healthier Indiana Insurance Program Task Force consisting of 13 lay members. The Office of the Secretary is to provide administrative support and staff for the Task Force. The Task Force is to study, monitor, make recommendations, and provide guidance to the state concerning the Healthier Indiana Insurance Program; to develop methods to increase the availability of affordable coverage for all Indiana residents; to develop an education and orientation program for individuals participating in the Program; and to make recommendations to the Legislative Council before November 1, 2008. The committee is to operate under the policies governing study committees adopted by the Legislative Council. Task Force members are not eligible to receive per diem reimbursement or reimbursement for travel expenses incurred.

Explanation of State Revenues:

Employer Wellness Program Tax Credit: This bill establishes a nonrefundable tax credit for employers that provide certain wellness programs to their employees. The tax credit could potentially reduce state revenue from the Adjusted Gross Income (AGI) Tax, the Financial Institutions Tax, and the Insurance Premiums Tax. Based on survey research estimating the prevalence of wellness programs and the average cost of these programs, the tax credit could potentially reduce revenue by $600,000 to $2.5 M annually beginning in FY 2009. The revenue loss could begin in FY 2008 if taxpayers adjust their quarterly estimated payments. To the extent that additional firms add wellness programs as a result of the tax credit, the revenue loss would be higher that the estimated range. In addition, cost inflation and employment trends suggest that the revenue loss could potentially grow by 1% to 2% per year.

Background Information: The bill provides a nonrefundable tax credit against a taxpayer's AGI Tax, Financial Institutions Tax, or Insurance Premiums Tax liability for the cost of providing a wellness program to the taxpayer's employees that rewards:

(1) overweight employees for losing weight and all employees for maintaining a healthy weight; or
(2) employees for no using tobacco.

The tax credit is equal to 50% of the cost incurred by the taxpayer in providing the wellness programs during the taxable year. The tax credit is nonrefundable, but excess credits may be carried forward to succeeding taxable years. The bill prohibits a taxpayer from carrying back excess credits. If the taxpayer is a pass through entity and does not have a tax liability, the credit could be taken by shareholders, partners, or members of the pass through entity in proportion to their distributive income from the pass through entity. Since the credit is effective beginning in tax year 2008, the fiscal impact would likely commence in FY 2009. However, the fiscal impact could begin in FY 2008 if taxpayers with wellness programs reduce their quarterly estimated payments the first half of 2008.

Revenue from the corporate AGI Tax, the Financial Institutions Tax, and the Insurance Premiums Tax is deposited in the state General Fund. Eighty-six percent of the revenue from the individual AGI Tax is deposited in the state General Fund, and 14% is deposited in the Property Tax Replacement Fund.

Survey research by the Kaiser Family Foundation suggests that about 5% of private sector employees in Indiana could potentially have access to wellness programs offering weight loss programs and/or smoking cessation programs. Survey research by the Wellness Councils of America (WELCOA) suggest that only about 6% of employer-provided wellness programs offer no incentives to encourage program participation by employees. Based on the median employment scale and wellness program budget of firms responding to the WELCOA survey, the average cost of employer-provided wellness programs could range from about $10

to $40 per employee. Current estimates by the Bureau of Labor Statistics indicate private sector employment totals about 2.5 million, with long-run growth of about 1.1% annually.

Rural Health Care Pilot Program: Under the bill, the Rural Health Care Pilot Program Support Fund is established to make grants to health care providers who participate in a Rural Health Care Pilot Program to make the local match required as a condition of the provider's participation in the pilot program. The money in the Fund will consist of money appropriated, designated, or dedicated by the General Assembly, and gifts, grants, and bequests. Money in the Fund at the end of the fiscal year does not revert to the state General Fund.

The Office of Technology will administer the Fund, including prescribing the grant application forms and establishing the grant procedures. The Treasurer of State will invest money in the Fund and may contract for assistance in the management of the Fund with any expenses paid from the Fund.

Background: There are no data available to indicate if any Indiana rural health care providers are participating in this Federal Communication Commission (FCC) program aimed at helping public and nonprofit health care providers build state and regional broadband networks. This network works on Internet2, which is a dedicated nationwide backbone connecting government research, academic, and public and private health care institutions. The program provides up to 85% of the construction costs of a dedicated health care network and up to 85% of the costs of connecting to the nationwide Internet2. However, the Internet2 connection is not required, but may be requested by applicants. The FCC estimates that approximately $55 to $60 M is available for the pilot program in 2007.

Medicaid: See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program.

(Revised) *Penalty Provision:* The bill establishes a new Class A infraction for smoking in certain enclosed public places, sports arenas, or enclosed places of employment. The bill provides for certain exceptions. The maximum judgment for a Class A infraction is $10,000, which would be deposited in the state General Fund. However, any additional revenue would depend on local enforcement.

Explanation of Local Expenditures: *Expansion of Risk Pool in State Employee Health Benefit Plans*: The bill will affect expenditures for health insurance for local units. Whether the bill will increase or decrease expenditures is unknown. Additionally, the impact will vary depending upon each local unit.

Employer-Sponsored Health Coverage for Children to Age 24: This bill requires a policy of accident and sickness insurance and an HMO contract to provide coverage for the child up to age 24 at the request of the policyholder, certificate holder, or subscriber. This provision will affect expenditures for health insurance for local units. Whether the bill will increase or decrease expenditures is unknown. Additionally, the impact will vary depending upon each local unit.

Public Employer Wellness Programs: Local units of government could experience an increase in expense depending on the type of wellness program established. The wellness program has to reward overweight employees for losing weight and all employees for maintaining a healthy weight or employees for not using tobacco. There are approximately 2,750 local units of government that employee about 190,000 employees. If each employer gave a $100 reward for weight control or not using tobacco, the impact could be $19,000,000. The impact would be offset to some extent by possible future reduced health costs by the employer.

Explanation of Local Revenues: *HCI Property Tax Levy Changes:* The bill amends the HCI property tax levy for 2008 to be based on taxes first due and payable in 2007. The levy would be determined in the same manner in subsequent years; effectively the levy would be capped at the 2007 rate for subsequent years. The bill removes a provision that requires the HCI levy to be based on a three-year rolling average of payable claims attributed to the county subject to a maximum levy based on assessed value growth. This provision would have taken effect for taxes due and payable in 2009. The estimated maximum levy under current law is estimated at $63.7 M for 2008; the statewide levy under this proposal is estimated to be $61.2 M. HCI collections are transferred by the counties to the state HCI Fund for reimbursement of eligible physician and transportation provider claims up to an amount of $3 M. The balance of the fund is transferred to the Medicaid Indigent Care Trust Fund to provide state matching funds to leverage federal funds for HCI hospital add-on payments and other Medicaid expenditures.

(Revised) *Penalty Provision:* If additional court actions are filed and a judgment is entered, local governments would receive revenue from court fees. However, any additional revenue would depend on local enforcement.

State Agencies Affected: OMPP and CHIP Program, Family and Social Services Administration, Department of State Personnel; and Department Of Revenue.

Local Agencies Affected: All.

Information Sources: FSSA, Christy Tittle, Department of State Personnel, 317-232-3241; 2006 Annual Membership eSurvey, Wellness Councils of America, http://www.welcoa.org/. Employer Health Benefits Annual Survey, 2005 & 2006, Kaiser Family Foundation, http://www.kff.org/. State and Area Employment, Hours, and Earnings, U.S. Bureau of Labor Statistics, http://www.bls.gov.

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